Manurewa High School
Medical Form

To ensure our Student Support Team is providing the best possible care for your child in any illness/emergency situation, please answer the following. While this information is **strictly confidential**, it may be necessary for the safety of your child and others to inform relevant staff of medical conditions. This medical form will be filed in the School Health Centre.

If you DO NOT want your child to participate in a Health and Wellbeing Assessment please contact the school Health Centre healthcentre@manurewa.school.nz.

Student's Name: ..... **Year Level**: .....

1 **Family Doctor**: ..... Phone No: .....

Dentist: ..... Phone No: .....

2 **Medical Conditions:**

My child has or has had the following disabilities, allergies or medical problems which may affect his/her performance or activities at school:

Medical Conditions	✓ **Yes**	**Medication Required** [see below], **Other Details**
Asthma [see Section 10]		
Back / Neck Problems		
Diabetes		
Epilepsy		
Hay Fever		
Heart Conditions		
Hepatitis A or B / HIV		
Mental Health		
Migraines		
Nose Bleeds		
Past illness and / or operations or hospital admissions		
Recurring Abdominal Pain		
Rheumatic Fever		
Tuberculosis		
Other		

3 **Allergies:**

Allergic Reaction To	✓ **Yes**	**Specify Type**
Bee Stings		
Medication		
Food		
Other		
Nil Known		

4 **Medication:**

Please send **labelled** medication to the School Nurse if it is required for regular use or for emergencies [i.e. antihistamines for bee stings].

5 Does your CHILD have on a regular basis:

(a) Any medication not mentioned above?

(b) A course of treatment?

If **YES**, please detail

.....

.....

6 Does your child work with any external agencies on a regular basis?

If **YES**, please detail: .....

.....

7 Immunisation:

Has your child had tetanus immunisation? *[please circle answer]*

YES / NO If **YES**, list date of last tetanus injection .....

8 Sensory Loss: **YES / NO** *[please circle]* If **YES**, specify type and degree below:

Problem Area	**Right**	**Left**	**Bilateral**	**Amount** *[e.g. mild, 100%]*
Visual *[Eyesight]*				
Hearing				
Device Used *[e.g. Glasses, Hearing Aid]*				

9 Other Relevant Conditions: *[e.g. cardiac murmur – limited PE, Cystic Fibrosis, etc]*

If **NO**, write N/A and go to Section 10.

If **YES**, please detail: .....

.....

10 Asthma Sufferers Only:

Does your child have an Asthma Action Plan? ◯ **YES / NO** ◯ *[please circle]*

If **YES**, please give a copy to the School Nurse. *If using preventers, the Asthma Society recommends having an Action Plan [which requires updating every 6-12 months]. See your GP/Practice Nurse.*

11 Permission for Administering Medication: *[e.g. Panadol, Antihistamine, Mylanta, topical creams, cough syrup].*

In some circumstances it may be necessary for medication to be administered for such things as headaches, period cramps, hay fever, sinus, colds. **I give permission for the School Nurse to administer this treatment if necessary.**

Parent/Guardian Signature .....

In case of a serious accident or emergency, an ambulance will be called. A parent/guardian will also be called, so please ensure that the School has your most current contact details.

We appreciate that during the course of enrolment, family circumstances and a student's health may change. It would be very much appreciated if the School is notified as soon as possible by either:

[a] A phone call to the Health Centre
[b] A phone call to the Main Office
[c] A note to the Kaitiaki

Note This information is for School purposes. The School reserves the right to pass on this information to other agencies it sees fit to hold and store the information.